Certificate by medical attendant: Hospital Cash/Major Medical benefit

METROPOLITAN
Together we can

To be completed IN PRIVATE by the MEDICAL ATTENDANT who treated and/or referred the insured to hospital, and returned IN A SEALED ENVELOPE TO INDIVIDUAL LIFE CLAIMS, METROPOLITAN, P O BOX 2212, bellville 7535.

This certificate is required to assess a Hospital Cash benefit/Major Medical benefit claim under policy:

issued by Metropolitan on the life of:

1. (a) Full names of patient:
   (b) Identity number of patient:
   (c) Name of the patient's regular doctor:
   (d) Date since which you have been the patient's doctor:

2. (a) What is the reason (condition) for hospitalisation/treatment:
   (b) Diagnosis:
   (c) Date on which diagnosis was made:
   (d) Treatment prescribed:
   (e) When and by whom was the patient first treated for this condition?
   (f) If possible, please state the date on which the patient first became aware thereof:

3. (a) Are you aware of any sickness or habit which might have given rise to the present condition? (Please describe fully and give dates, if possible):
   (b) Is or has the insured ever been a smoker? (If yes, state quantity and since when?)
   (c) Are you aware if the patient was treated by any other doctor, hospital or clinic during the last five years? (Please state the name of the doctor, hospital or clinic, the illness and the dates, if possible):
   (d) Have you treated the patient for any other ailment, sickness or injury during the past five years? (Give particulars and dates):
   (e) Could the patient's condition be attributed to the use of alcohol, drugs, self-inflicted injury, violation of the law or participation in hazardous sport? (details if applicable)

4. (a) Is there any reason to believe that the patient's condition is in any way due to, or arises from Aids or HIV infection?

01163

(b) If "yes" please give full details

(c) Has the patient ever been tested for HIV antibodies?

(d) If in the affirmative, the date(s) done and results of the test(s):

(e) State the reason(s) why an HIV test was done:

5. If the patient was referred to hospital:

(a) (i) Date admitted to hospital:

(ii) Date discharged from hospital:

(iii) Name and address of hospital:

(iv) Patient reference number:

(b) (i) Was the patient at any stage confined to an intensive care unit?

(ii) Date admitted to ICU, if in the affirmative:

(iii) Date discharged from the intensive care unit:

6. Please state all medical and surgical procedures carried out, with the names of attending doctors:

PROCEDURE	DATE	ATTENDING DOCTOR

7. Have you ever treated the patient for any of the following? If “Yes”, state **dates of consultations and diagnosis.**

(a) His/her lungs?

(b) His/her heart or circulation?

(c) His/her digestive system or liver?

(d) His/her nervous system?

(e) His/her kidneys, bladder or reproductive organs?

(f) Any STD?

(g) His/her eyes (excluding errors of refraction), ears, nose or throat?

(h) His/her skeleton, joints or muscles?

(i) His/her glands or blood?

(j) Growths?

Dated at | this | day of | in the year

Signature of medical practitioner

Name of medical practitioner:

Qualifications: | Practice number:

Address:

Telephone number:

To enable Metropolitan to settle your account we require the **policy number** as well as name of the insured on your statement.

01163